Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4009AGC	A. BUILDING _____ B. WING _____	C 12/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME OF FAITH AND HAPPINESS	6418 SPRING MEADOW DRIVE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 12/7/10. The grading re-survey was conducted for the 1/26/10 and 6/15/10 surveys. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of A. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, Category I residents. The census at the time of the survey was three. Three resident files were reviewed and four employee files were reviewed. The following deficiencies were identified:	Y 000		
Y 532 SS=C	449.260(1)(g)(1)(2) Activities for Residents NAC 449.260 1. The caregivers employed by a residential facility shall: (g) Post, in a common area of the facility, a calendar of activities for each month that notifies residents of the major activities that will occur in the facility. The calendar must be: (1) Prepared at least a month in advance. (2) Kept on file at the facility for not less than 6 months after it expires.	Y 532		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 532	Continued From page 1 This Regulation is not met as evidenced by: Based on observation on 12/7/10, the facility failed to post a monthly calendar of current activities for December 2010. This is a repeat deficiency from the 6/15/10 annual State Licensure survey. Severity: 1 Scope: 3	Y 532		
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This Regulation is not met as evidenced by: Based on record review on 12/7/10, the facility failed to ensure that 1 of 3 residents received an annual physical (Resident #1). Severity: 2 Scope: 2	Y 859		